

CSP Parking Reimbursement Request Form

INSTRUCTIONS: Complete the information below for parking expenses incurred or paid for by you.

_____|_____|_____|_____|_____|_____|_____|_____|_____|_____|
Social Security Number Date of Birth (00/00/00)

Employer

Last Name

First Name

Home Address

City

State

Zip Code

Daytime Phone Number (Required)

E-mail Address

Be sure to provide all information requested, date and sign the form, then send it with your supporting documentation via FAX to FBMC at (850) 425-4608 or mail to FBMC, P.O. Box 1800, Tallahassee, Florida 32302-1800.

	PARKING
Month Parking Service was Provided	_____ _____ _____ _____ _____ _____ _____ _____ _____ _____ MONTH YEAR
Description/Service Provider	
Receipt(s)	<input type="checkbox"/> ATTACHED RECEIPTS
Total Expense	\$
Reimbursement Requested	\$

To the best of my knowledge and belief, my statements in this form are complete and true. I certify all of the following: I used the parking benefit for which I am requesting reimbursement above only for the purposes of parking at my Employer. I have received the services described above on the dates indicated, and the expenses are my out-of-pocket expenses that qualify as valid parking expenses under the Program. I have not been reimbursed previously for these expenses under the Program. These expenses have not been reimbursed or are not reimbursable under any other plan. I understand that the expenses reimbursed may not be used to claim any federal income tax deduction or credit, or to claim reimbursement under another plan. I authorize a deduction from my Commuter Savings Account in the amount of the requested reimbursement.

Employee Signature

Date

**For questions, please contact FBMC Customer Service at 800-342-8017.
Visit www.myFBMC.com for program information.**